Tamaris (Templemoyle) Limited

Ormesby Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 5 January 2016 and was unannounced. This meant that the provider did not know we would be visiting. A second day of inspection took place on 6 January 2016, and was announced. The service was previously inspected on 19 May 2014 and was meeting the regulations we inspected.

Ormesby Grange Care Home is situated in Middlesbrough and provides care and accommodation for up to 116 older people, some of whom are living with dementia. It is a purpose built, three storey home. Each floor housed a different unit; 'Daisy' unit on the ground floor for residential care, 'Tulip' unit on the first floor for nursing care and 'Rose' unit on the second floor for nursing care. At the time of the inspection 61 people were using the service.

The manager was applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care

Summary of findings

Act 2008 and associated Regulations about how the service is run. The manager was being supported by a peripatetic manager and a quality manager from the provider.

The service was not always safe. Medicines were not always managed safely. Records relating to medicines were not completed correctly placing people at risk of medication errors. Medicine stocks were not properly kept which meant that medicines that people needed were not always available. Audits of medicines were undertaken, but they did not identify the errors we observed during the inspection.

Risks to people were not always assessed, and steps were not always taken to minimise them. Where risks assessments were undertaken, they were not always regularly reviewed to ensure they matched people's current needs. Risks assessments were not always used to plan or deliver people's care in a way that minimised the risk to them.

Staffing levels were insufficient to support people safely. Staff and people's relatives had expressed concern about staffing levels to the provider, but no action had been taken. During the inspection we observed that low staffing levels impacted on the care that people received. Pre-employment checks to ensure staff suitability to work with vulnerable people did not always take place. Staff did not receive a regular system of supervision and appraisal to support them in their role.

These were breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

Policies were in place to ensure that people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were protected. Staff had a working knowledge of the principles of the MCA, and knew how people's consent to support could be obtained.

People were supported to maintain their health through access to food and drinks. Meals were appealing and the dining experience was pleasant and encouraged people to maintain good nutrition.

The service worked with professionals to maintain and promote people's health and wellbeing.

People were treated with dignity and respect and people and their relatives spoke positively about the care they received. We observed positive and caring interactions between people and staff. Staff made an effort to speak with people and clearly knew them and what was important to them.

Staff had a working knowledge of how to respond to complaints, but it was not always possible to tell from records what investigations had taken place or lessons learned.

People received care and support that was responsive to their needs and reflected their preferences. Staff were effective at ensuring that changes to people's preferences or needs were passed on to colleagues.

People had access to activities that reflected their interests and preferences, though some staff told us that people living with dementia did not have many specialised activities.

Staff told us that they had not always been supported during management changes that had taken place in 2015. People and their relatives spoke positively about the manager.

Quality assurance checks were undertaken on a regular basis, and these were monitored by the provider. The manager felt supported by the provider.

Feedback was sought from people, relatives, staff and external professionals on how to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Medicines were not always managed safely.

Risks to people were not always assessed, and steps were not always taken to minimise them.

Staffing levels were insufficient to support people safely, and pre-employment checks to ensure staff suitability to work with vulnerable people did not always take place.

Is the service effective?

Requires improvement

The service was not always effective.

Staff were not supported through a regular system of supervision and appraisal.

Staff understood and applied the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

People received suitable support with food and nutrition and were able to maintain a balanced diet.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People and their relatives spoke positively about the care they received. We observed positive and caring interactions between people and staff.

The service knew how to arrange advocacy support for people that needed it.

Is the service responsive?

Requires improvement

The service was not always responsive.

It was not always clear how complaints had been investigated and responded to.

People received care that reflected their personal needs and preferences.

Most people had access to a range of activities that reflected their preferences. People who were living with dementia did not always have access to relevant activities.

Summary of findings

Is the service well-led?

The service was not always well-led.

People and their relatives spoke positively about the manager, but staff said they had not always been supported by the provider during management changes.

Quality assurance checks were undertaken on a regular basis.

Feedback was sought from people, relatives, staff and external professionals on how to improve the service.

Requires improvement

Ormesby Grange Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 January 2016 and was unannounced. This meant that the provider did not know we would be visiting. A second day of inspection took place on 6 January 2016, and was announced. The service was previously inspected on 19 May 2014 and was meeting the regulations we inspected.

The inspection team consisted of two adult social care inspectors, two specialist advisors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this inspection, their area of expertise was care for older people.

The registered provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team and health and social care professionals to gain their views of the service provided at this home.

During the inspection we spoke with seven people who lived at the service and ten relatives. We looked at 12 care plans, and Medicine Administration Records (MARs) and handover sheers. We spoke with 15 members of staff, including the manager, the peripatetic manager, the quality manager, the regional operations manager, senior carers and carers and members of the domestic and kitchen staff. We also spoke with two external professionals who work with the service. We looked at four staff files, which included recruitment records. We also completed observations around the service, in communal areas and in people's rooms with their permission.

Inadequate

Is the service safe?

Our findings

We looked at how medicines were handled and found that the arrangements were not always safe. Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were within the recommended range. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

However, records relating to medicines were not completed correctly placing people at risk of medication errors. Medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose. Arrangements had been made to record the application of creams by care workers. However, these records were sometimes missed and others did not match the records on the medicine administration record chart. This meant that it was not possible to tell whether creams were being used correctly.

When we checked a sample of medicines alongside the records we found that five medicines for three people did not match up so we could not be sure if people were having their medication administered correctly. Three medicines for two people were not available. This means that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increases the risk of harm. We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This information would help to ensure people were given their medicines in a safe, consistent and appropriate way. For example, one person was prescribed a medicine that could be used for agitation and anxiety. There was no care plan or guidance in place to assist care staff in their decision making about when it would be used. For another person the prescribed dose had changed but the guidance had not been updated to reflect this.

Some people had medicines administered covertly. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. We saw that the GP had authorised covert administration for people who did not have capacity and were refusing essential medicines. However the information on how this would be done was not clear. This information would help to ensure people were given their medicines safely when they were unable to give consent.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that whilst the home had started a stock balance column on the medication administration chart, where issues were found the manager was not notified so that action could be taken. We were told that audits were completed regularly; however they had not identified the issues found during our visit.

Risks to people were not always assessed, and steps were not always taken to minimise them. One person was self-administering some of their medicines. However, a risk assessment had not been undertaken to ensure they were safe to do so. Another person had differing information recorded about their mobility needs, with conflicting information about the level of support required. The same person had a discharge letter following a stay in hospital advising the service to develop a plan to manage the person's behaviours that challenged. There was no plan in place, and during the inspection we saw staff approaching the person in a way that was inappropriate to their needs. This led to the person becoming more agitated. Another person had behaviours that challenged that had resulted in verbal and physical attacks on staff. These incidents were recorded in the person's case notes but there was no evidence of any learning or change in the plan of care to respond to the incidents. One member of staff working on the floor where the person lived was unaware that they had behaviours that challenge. Another person was receiving end of life care. Their preferred priorities were recorded, but their care plan appeared to be a record of contacts and visits from the district nurse and GP as opposed to a plan that detailed their care needs and risks to their health. Another person had been assessed as being at high risk of falls but there was no documented review of their needs or the risks to them in the three months leading up to our inspection.

Inadequate

Is the service safe?

These were breaches of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014

The service did not always check people's suitability to work with vulnerable people. Staff files contained application forms, references, including – where possible – from previous employers and proof of identity. However, two members of staff did not have Disclosure and Barring Service checks recorded. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Two other members of staff had dates that their DBS application was sent recorded but no evidence that the result had ever been received.

This was a breach of Regulation 19 Health and Social Care Act (Regulated Activities) Regulations 2014

The service used a staffing tool to assess how many staff were needed to support people safely. Morning staffing (8am to 2pm) levels were two senior carers and three carers on Daisy unit, two senior carers and three carers on Tulip unit and one nurse and two carers on Rose unit (in addition, one additional carer was deployed on Rose unit at all times to support a person requiring 1:1 care). Afternoon staffing (2pm to 8pm) levels were one senior carer and three carers on Daisy unit, two senior carers and three carers on Tulip unit and one nurse and two carers on Rose unit. Night staffing (8pm to 8am) levels were one senior carer and two carers on Daisy unit, one senior carer and two carers on Tulip unit and one nurse and one carer on Rose unit.

The building was large, with each floor containing four lounge areas, four bathrooms and a dining area. Throughout the inspection we noticed people spending long periods of time in areas of the building that were not observed by staff. Twice during the inspection we heard people calling out for several minutes for assistance, which was only given when an inspector walked to the opposite end of the building to find staff. On another occasion, we observed a member of domestic staff intervening to assist with personal care so that care staff could assist another person. We also saw staff completing written records outside a lounge with their back to the lounge doorway.

There were no staff in the lounge. A person living with dementia picked up a cup of half full tea and put it on another person's lap. When that person objected, they placed it on a chair. Staff did not see this.

We noted that three people living on Tulip unit needed hoist support for mobility, and one person had requested female only care. The staffing rotas we looked at did not appear sufficient to cover this. Staff told us that they moved around between the floors to assist where needed, but we did not see any plan in place to manage this safely without increasing risk to people living on the floors they had left.

Staff told us that they had raised their concerns about staffing levels with management at the service, and had been told that there were enough staff. One said, "I feel quite powerless about the constant short staffing. We can tell managers but just get told they've used the [provider's] guidance and they have no flexibility. We're just told to get on with it. It's like because they have this staffing tool they don't listen to what we're actually experiencing on every shift. They are approachable but they're not effective at changing anything. We do not have time to spend with residents, definitely no time to chat." Another said, "I think we need another member of staff. It can be chaos…It gets mentioned to [management] but they turn around and say the system we use shows there are enough." Another member of staff said, "We do have time to chat to people but usually it's when we're helping them with personal care." Another said, "We used to have time to sit and talk about old photographs with people in reminiscence sessions but now no-one does it; we just don't have time. There's no community groups here, no advocates or anything like that. If you [are living with dementia], you just sit with the TV on, it's not good enough."

One relative told us that they did not think staff had enough time to support their relative with eating. Another relative told us that they had raised concerns with management about staffing levels as they, "could see how [staff] were struggling." A third relative told us that a person was supposed to have assistance with shaving every day, but this had not happened. When they raised it with staff they were told that staff did not have time as they were too busy. A fourth relative told us they had visited a person one afternoon who was in need of assistance to change clothes.

Inadequate

Is the service safe?

When they asked staff to help with this, they were told that staff would leave it for the night shift to do as they were busy. Our judgment was that staffing levels were insufficient to support people safely.

This was a breach of Regulation 18 Health and Social Care Act (Regulated Activities) Regulations 2014

Systems were in place to deal with safeguarding incidents. The service had a safeguarding policy, which contained guidance to staff on the types of abuse that can occur and descriptions to assist them identifying them. There was a framework for reporting and investigating incidents, and this was followed when they occurred.

Emergency plans were in place to manage incidents at the service. Each person had a personal emergency evacuation plan ('PEEP'), containing information on their mobility and support needs in case of an emergency. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The PEEPs were regularly reviewed to ensure they were up-to-date. There was also a business contingency plan, which contained information to assist staff in providing a continuity of care in emergency situations.

Records showed that fire alarms, emergency lights and fire doors were checked on a monthly basis. Maintenance checks were also carried out on the nurse call system, window restrictors, mobility equipment and contaminated waste storage on a regular basis. Required certificates in areas such as PAT electricity testing, hoist tests and gas safety were up to date.

Requires improvement

Is the service effective?

Our findings

Staff told us they received a monthly supervision that was paper-based and did not involve a meeting or interaction with managers. One said, "The administrator pre-prints the supervision documents and then sends a copy to each member of staff. We're supposed to read the points made on the form and then sign it and send it back. We're not asked about what they should include and no-one checks if we've understood or read everything." We looked at the supervision records of thirteen staff that were signed between October 2015 and December 2015. We found that each member of staff received the same supervision document, which was not individualised to staff based on their role, competence or level of responsibility. In two cases, additional specific information had been added to a person's supervision record but there was no indication that this had been followed up. For instance, a manager had instructed one member of staff in their supervision dated October 2015 to research dementia, cognition and swallowing problems. The extent of the research required was not included and we could not find a follow-up to this. Sections available for individual staff actions, tasks, research and training were blank in all but two of the records we looked at. One supervision record included positive feedback for the member of staff and commended them for their "excellent practical skills…and very high standards." This showed us that staff were sometimes given positive and encouraging feedback but this was not offered consistently or in the majority of cases.

The focus of supervision records we looked at was on issues relating to performance and discipline, rather than staff development and recognition of good practice. There was evidence that issues around short staffing had impacted the quality of work staff were able to provide. For instance, the general supervision document dated October 2015 stated, "Staff not to write on the cleaning schedule 'short staffed' or 'no time'" and, "Unfortunately the home is a busy home and we all have delegated tasks." We did not find evidence that support had been put in place for staff who felt they could not complete tasks because of the volume of work or what policies managers had implemented to address the consequences of short staffing. Supervision records indicated that communication between staff and people was a priority for managers but it was not always clear that there were tools, resources or training to facilitate this. For instance, a general supervision record stated, "Staff to be skilled communicators to ensure privacy and confidentiality of [people]." There was no additional information about this and it was not clear how staff should interpret or apply this message.

Staff we spoke with told us that the standardised supervision forms were not supplemented with regular one-to-ones or meetings with managers. One member of staff said, "I haven't been approached by a manager about training or professional development in the last nine months." Staff we spoke with told us they couldn't remember the last time they had an annual appraisal. We looked at the appraisals folder and saw that there was no documented evidence of appraisals since 2013.

This was a breach of Regulation 18 Health and Social Care Act (Regulated Activities) Regulations 2014

Staff told us that induction processes were well organised and had allowed them to get to know people and how to meet their needs. One said, "My induction was okay. I had an orientation around the building, I shadowed an experienced carer for a week and then I was matched with them on shifts for a little while just to make sure I was comfortable with everything. The training I got to start with was also very good, like how to change a catheter. We did this in practice exercises, which really helped."

Staff told us they had been given dementia training and they felt this was specialist enough to look after people at the service. One member of staff told us they'd noticed an improvement in the standard of training recently. They said, "For a while everything was online and we never had time to do it but they [provider] have reintroduced practical training, which is much better. The dementia and behaviour that challenges training is especially good." Staff told us that although training had improved recently, they were concerned about the lack of training for the new nursing unit. One care assistant (LR) said, "They [provider] didn't give us any extra training for the new unit. I feel out of my depth up there, they should've given us some preparation or support for it." We looked at the training tracker that was used by the manager to identify when staff needed training updates or refreshers. There were 90 staff members on the tracker. 100% of staff had up to date training in manual handling, 20% of staff had been trained in behaviours that challenge and 9% of staff had infection prevention and control training. The manager told us that they had a plan in place to ensure that all staff received relevant training in 2016.

Requires improvement

Is the service effective?

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. 53 people at the service had DoLS authorisations in place. Where relevant, capacity assessments had been undertaken and were reviewed on a monthly basis. We saw that one person's monthly mental capacity review had not taken place for three months, and asked a member of staff why this was. They were not able to explain it and said, "[Person] must've just been missed." Where appropriate, DNACPRs were completed, stating discussions with relevant parties had taken place.

The service supported people to access food and nutrition. Two care assistants had undertaken a catering course focused on under nutrition. The course had instructed staff in the specialist nutrition needs of older people, older people with diabetes and those living with dementia. Staff had also completed modules on how to prepare fortified diets, altered consistency diets and high fibre diets. Staff had prepared a review of the home's rolling menu as part of their training. This had improved the menus by making them more person-centred. For instance, meal times had been added to menus alongside more specific information on the types of soups, sandwiches and vegetables available. Care assistants had worked more closely with catering staff to provide more oily fish on the menu and to offer culturally appropriate foods. Staff we spoke with told us that menus were more varied now and people had a better range of choices with their meals.

We observed three staff handovers and found that nutrition and hydration needs were discussed in detail, including changes in appetite or the need for a special diet. We saw that staff had a good understanding of the risks associated with poor nutrition. For example, they discussed the need to refer a person to a community dietician and senior staff asked care assistants to offer a wider variety of food to a person who had lost their appetite the day before.

We observed people and staff during the lunch service on two days. Staff had a good understanding of people and were able to act when a person refused to eat or did not like the food. One person who was very agitated and did not want to sit at a dining table was supported to eat in a corridor, where they felt calmer. The member of staff had a patient and kind manner and was able to encourage them to eat most of their lunch.

Staff discussed nutrition and hydration as part of routine twice-daily handovers. For example, care assistants discussed their knowledge of a person who had refused to eat the day before and considered contributing factors to this. Staff discussed the nutritional needs of another person who had been changed to a pureed diet by a dietician and shared their knowledge of the individual to ensure they would be supported at mealtimes. This meant that people were supported to access food and nutrition.

During our observations of three handovers, we saw the medical and health needs of people were discussed in detail. Senior care assistants had a clear understanding of who needed to be monitored by them and who needed to be assessed by a health professional. There was clear communication between night shift and day shift staff to ensure this took place. For example, staff discussed strategies to support one person who had refused to give a urine sample despite complaining of pain. Night shift staff told their colleagues about another person who had reduced their fluid intake the night before and it was noted that this person should be monitored and encouraged to drink more. Staff agreed to request an occupational therapy appointment after a care assistant raised concerns about a person's posture in an adapted chair that had been provided for them.

From looking at care plans, we saw that staff had involved multidisciplinary professionals appropriately and proactively, including GPs, dentists and the falls team. We found evidence that staff had followed the advice of professionals, such as when they had been instructed to increase visual monitoring of a person at risk of falls. Staff had arranged the installation of bed sensors in response to a person's falls assessment. An external professional who works with the service said, "[The service is] taking on

Requires improvement

Is the service effective?

board national guidelines and receptive to learning…They're really receptive to training and wanting to do the right thing. It's a really lovely home. They are taking steps to getting the home to the right level."

The service was in the process of making the environment more dementia friendly. Support railings and bathroom doors had been painted in distinct colours, and some people's bedrooms had their names and photographs on them. One person's room had a sign on by a relative to tell them that was their room. However, we noted that not all rooms had names and pictures on. Because there were lots of vacant rooms, it was sometimes unclear whether doors had been missed or whether the rooms were vacant. The manager said that the service was in the process of improving signage throughout the service.

Good

Is the service caring?

Our findings

People spoke positively about the care they received. One person said, "I'm quite happy here. They're all very kind." Another said, "Nothing is too much trouble. They try their hardest. They're good staff and good in the office too." A third person said, "They're nice [staff]. It's comfortable." Another person said, "You feel as if you are looked after…I've not had any complaints."

People's relatives also spoke positively about the care staff gave. One said, "They have looked after [my relative] really well. All their needs are catered for." They went on to explain that staff had helped their relative to increase their mobility and independence, and that the family was relieved the person was living at the service. Another relative said, "The [staff] are excellent." A visitor from a local church said they visited lots of services in the area and, "This is one of the best. The care is good."

Throughout the inspection we saw that people were cared for with dignity and respect. Before care was given, staff asked for consent from the person. We saw this included knocking on a person's bedroom door before entering and asking a person if they were ready to move when transferring them with a hoist. Where people demonstrated complex behaviour needs, we saw staff were patient in obtaining consent and helped to distract and divert people who became anxious because they needed help with personal care. Where people needed support with eating, this was done at a relaxed, unhurried pace which helped the people to relax. Staff also encouraged people to attempt things for themselves, for example eating and mobility, before intervening when help was required. Where people indicated that they needed help, staff approached them and asked privately how they could assist in order to maintain their confidentiality.

We saw that people were treated in a kind, caring way. Staff spoke to people as they moved around the building, and were clearly knowledgeable about them and their families. Where people had been visited by relatives, staff spoke with them about their family news and we saw that people enjoyed this. Where people were watching TV or reading in communal areas, staff made an effort to speak with them when time allowed. We saw people and staff enjoying jokes with one another, though always in a respectful and professional way. Where staff were present and people needed assistance, we saw that they intervened quickly and discreetly and offered reassurance to people.

At the time of our inspection nobody was using an advocate. Advocates help to ensure that people's views and preferences are heard. Advocacy services were not advertised anywhere within the service, but the manager explained that they would arrange for an advocate to be appointed if the need arose.

Requires improvement

Is the service responsive?

Our findings

A 2015 supervision record had been issued to all staff that stated "most complaints" resulted from communication issues with staff. We looked at the complaints file and found that recording of complaints had been sporadic and inconsistent. The last recorded complaint was dated July 2015. The complaints file included confidential information relating to staff who had made private complaints about each other, confidential staff supervision notes and details of a staff complaint regarding a third party contractor. There was no tracking system in place to record when complaints were resolved or to evidence what had been changed as a result of the complaint. Some complaints had a resolution recorded. Where this was this case we found the action to be appropriate, such as in the case of a visitor who had presented a risk to people through their aggressive attitude. Where a complaint had been received from a person or a relative, in some cases appropriate action was documented. For example, it was documented that staff had been given supervision when a relative complained about their family member's poor personal hygiene when they had visited.

Staff we spoke with had a good understanding of the complaints procedure and could tell us what they would do if a person or visitor made a complaint to them. We did not find a robust complaints investigation process. One documented complaint included concerns from a relative about the lack of opportunities for activities or social stimulation and that staff had failed to notice a fungal infection. There was no documented resolution to the complaint and the staff we spoke with said they did not know what had happened. We asked the peripatetic manager about this. They said that complaints would normally be stored and tracked electronically. Managers did not have a coherent system of monitoring in use with which to investigate complaints once they were received and so it was not clear how or if they were followed up. This meant that we could not be certain complaints were handled or investigated appropriately.

People received care and support that was responsive to their needs and reflected their preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Care plans were in place for areas including communication, capacity, mobility, personal hygiene, skin integrity, cognition and specialist needs. These were reviewed on a monthly basis to ensure that they contained information on people's current needs. Care plans also included a monthly dependency evaluation that staff could use to track changes in need relating to mental capacity and consent, mobility, nutrition, continence, personal hygiene, psychological and emotional needs and communication. Care plans contained evidence that people had been involved in making choices about the care and support they wanted, and throughout the inspection we saw staff giving people choices when they delivered support.

Each person was assigned a key worker from the care team. This system was in place to ensure that people would receive consistent support and care from the same member of who staff who would get to know them. A care assistant told us this system worked well and helped them to make sure people were supported with personal tasks. They said, "As a key worker we have responsibility to make sure that we keep peoples' bedrooms clean and tidy, help them with things like tidying their wardrobe and making sure they have the toiletries they need and want. We get to know their likes and preferences and so we can make sure they're happier than if they were just looked after by a general team." A senior care assistant said, "The key worker role is really important. It's a reminder that no matter how busy we are, we each have the responsibility to look after individuals and make sure their rooms are just as they want them."

There was evidence that staff had previously used daily 'flash meetings' to discuss the needs of people and any safety issues in the home. We saw that the meetings had been documented and had been attended by staff from each department, including clinical leads, care assistants, domestic staff, laundry staff, cooks, maintenance staff, activities coordinators, administrators and care staff. Documents indicated that admissions and discharges, staff training needs and people at risk were regularly discussed as well as important updates on the use of antibiotics and other medication notes. However, records of the meetings ceased in October 2015. When we asked about this staff could not explain why.

We observed three handovers during our inspection. The handovers were detailed and documented, though we saw that attendance was not robustly managed as three care assistants were late to one of the handovers. Staff told us that the daily rota was arranged based on the needs of

Requires improvement

Is the service responsive?

people and the skill mix of staff. For instance, some people preferred personal care from a male member of staff. This meant that male staff often worked between different floors on the home to meet people's needs.

We found evidence that staff were able to respond to the personal needs of some people by working with their relatives. For instance, staff had been able to source a wheelchair for a person who wanted to spend Christmas at home.

Two dedicated activities coordinators were available in the home. Staff told us that the organised activities included bingo, sing-alongs, bowling, skittles and dexterity exercises. The home had a large, well-kept garden that one care assistant told us was used in the summer with barbecues and a paddling pool. Some care staff raised concerns with us about the lack of stimulation for people who were living with dementia. One said, "There's nothing at all going on for [people living with dementia] and no weekend activities at all. The garden looks nice but in reality it's used only if we have enough staff, which isn't very often." We did not see any specialised activities for people living with dementia during the inspection.

Where people had discussed their past with staff, they had been offered access to local services and organisations. For instance, staff had recorded that in conversation with one person they found out the person used to follow a religion. As a result staff had offered to arrange Holy Communion.

Requires improvement

Is the service well-led?

Our findings

Staff told us that they had not always felt supported during changes of management in 2015. One said, "The deputy manager is very approachable, very consistent. Managers seem to come and go here. They bring in new ideas but leave before they have a chance to change anything so it's not a very stable team." Another said, "The new nursing unit has had a lot of attention but it's been at the expense of everywhere else in the home… someone from head office just turned up one day and told us there was a new nursing unit opening. There was no information, no explanation, we were just told." A third said, One care assistant said, "There's no team organisation that I'm aware of, I'm not part of a specific team."

People spoke positively about the new manager. One person said, "[The manager] is great…really down to earth." A relative said, "[The manager] is very thorough." However, staff said that the provider had not always given them information on the changes to management or the service.

The manager carried out a number of audits to monitor and improve the service. The manager reviewed a sample of care plans on a monthly basis, and checked to see whether risk assessments and other information was up-to-date. The most recent report from December 2015 identified that a number of risk assessments had not been updated on a monthly basis as required, and the manager told us that they were working through a backlog to clear these. They said, "Every month a client should be risk assessed. A couple haven't been done and they [staff] have been told about it." However, we noted that audits of medicines had not identified the issues we discovered during the inspection.

The manager also undertook a number of checks around the service. They said, "I do equipment checks…dining room checks, bed rail and profile bed checks on each units." Records confirmed that these monthly checks were undertaken, most recently in December 2015. A general environmental check was also undertaken, monitoring areas such as cleanliness, tidiness, security and whether, '[The service] feels calm, relaxing and feels like a welcoming home…'

Feedback was sought from people, relatives and visiting external professionals through an electronic questionnaire completed on a tablet computer in the entrance to the building. The manager said, "With residents, we ask five a day using [a portable tablet.] The seniors, carers or I do it. I think if they see a different face doing it you get a different response and people might say to one person what they wouldn't say to the next. I relay positive feedback back to staff."

We reviewed a sample of the feedback questionnaires. A district nurse who visited on 31 December 2015 gave positive feedback, which included saying that they would be very likely to recommend the service to friends and family and that there was nothing they would change. A relative completed a questionnaire on 4 November 2015 and said their relative was 'well treated by staff' and appeared 'well cared for'. However, they also said they would like to be more involved with decision making at the service. A person completed a questionnaire on 29 December 2015 and said they felt safe living at the service and were treated with respect. We were told that the regional manager monitored the feedback received through questionnaires and they and the manager monitored it for any trends that emerged.

Staff meetings took place, and we saw minutes from the most recent one in December 2015. 20 members of care staff attended the meeting, and a number of issues were discussed including administrative changes, training and activities. Staff were thanked for their work and support. We also saw minutes of the 'health and safety committee' meeting from December 2015. 19 members of staff attended the meeting, and discussed health and safety assessments and general safety issues.

The manager told us that they felt supported by the provider in their role. They said, "They give me support. I just need to ring up and they send someone down [to help]." The registered manager was able to explain their responsibilities and described the notifications they were required to make to the Commission.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing levels were insufficient to support people safely and staff were not supported through a regular system of supervision and appraisal. Regulation 18(1) and (2)(a).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not always managed safely. Risks to people were not always assessed, and steps were not always taken to minimise them. Regulation 12 (2)(a), (b), (f) and (g).

The enforcement action we took:
We issued a warning notice requiring Ormesby Grange Care Home to be compliant with this regulation by 25 February 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Not all staff had completed or current Disclosure and Barring Service checks to confirm that they were suitable to work with vulnerable adults. Regulation 19(1)(a).

The enforcement action we took:
We issued a warning notice requiring Ormesby Grange Care Home to be compliant with this regulation by 25 February 2016.